INTERNATIONAL RESERVE POLICE OFFICER ASSOCIATION EXCHANGE PROGRAM

HON. JOE KNOLLENBERG

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 26, 2000

Mr. KNOLLENBERG. Mr. Speaker, I rise today to recognize and commend the International Reserve Police Officer Association Exchange Program. This program provides a unique opportunity for reserve police officers from American cities and towns to share information and go on patrol with their counterparts in other nations. The Association allows for the open exchange of reserve policing concepts between countries and between individual reserve officers.

This year marks the fifth year of the International Reserve Police Officer Association exchange program. Their 2000 international conference will be held in the United Kingdom. Officers from my home state of Michigan representing the Oakland County Sheriff's Department, Waterford Township and the City of Dearborn will visit Wales and England in August. The reserve police officers will patrol with both regular and special officers of the South Wales Constabulary, the Metropolitan Police and the City of London. A formal conference will be held on August 31 at New Scotland Yard.

I wish to extend to each officer, from both America and the United Kingdom, my sincere appreciation for their efforts in strengthening the bond of friendship and professionalism among reserve police officers. These individuals risk life and limb every day by volunteering their services to the public. Their dedication and hard work in protecting the public are to be enthusiastically saluted.

ON THE INTRODUCTION OF THE COMMUNITY ACCESS TO HEALTH CARE ACT OF 2000

HON. GENE GREEN

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 26, 2000

Mr. GREEN of Texas. Mr. Speaker, I rise today in support of the Community Access to Health Care Act of 2000, legislation I am introducing to help our states and communities deal with the crisis of the uninsured.

Over 44 million Americans do not have health insurance and this number is increasing by over a million persons a year. Most of the uninsured are working people and their children—nearly 74 percent are families with full-time workers. Ten percent of the uninsured are in families with at least one part-time worker. Low income Americans, those who earn less than 200% of the federal poverty level or $27,300 for a family of three, are the most likely to be uninsured.

Texas is a leader nationally in the number of uninsured, ranking second only to Arizona. About 4 million persons, or 26.8 percent of our non-elderly population, are without insurance.

The uninsured and under-insured tend to be more expensive to care for. They fall through the health care cracks. They put off going to a doctor until it is too late—and then they go to the emergency room. Instead of having available the wide variety of preventive measures and checkups that those of us with insurance take for granted, the uninsured often ignore the symptoms of what might be larger problems because they simply cannot afford to go to the doctor.

According to research done by the Kaiser Family Foundation, nearly 40% of uninsured adults skip a recommended medical test or treatment, and 20% say they have needed but not gotten care for a serious problem in the past year.

Uninsured children are at least 70% less likely, Kaiser reports, to receive preventive care. Uninsured adults are over 30% less likely to have had a check-up in the past year, uninsured men 40% less likely to have had a prostate exam and uninsured women 60% less likely to have had a mammograrm than compared to the insured.

The uninsured are at least 50% more likely than the insured to be hospitalized for conditions such as pneumonia and diabetes. Unfortunately, the uninsured are more likely to be diagnosed with fatal diseases at significantly later stages than are those with insurance. Death rates from breast cancer are higher for the uninsured than for those with insurance.

In many American cities, towns and rural areas, there is general agreement that—something needs to be done to track, monitor and serve the uninsured. We all pick up the tab for the uninsured in the end—why not have communities join forces to attack this problem on a local level? Why not spend our tax dollars wisely and invest in prevention rather than spend them foolishly paying for emergency room visits or lengthy hospitalizations?

The Community Access Program (CAP) embodies this idea; it stems from a very successful Robert Wood Johnson Foundation-funded project that showed that community collaboration increased access to quality, cost-effective health care. Last year, the Clinton Administration proposed and Congress passed the Community Access Program as a $25 million demonstration effort. This year, over 200 applications were received for approximately 20 grants. Obviously, the need for and the interest in this program is great.

The Community Access to Health Care Act of 2000 will authorize the Community Access Program for five years. It gives competitive grants to communities to help more uninsured people receive health care and to ensure that communities join forces to map a strategy for counting and dealing with the uninsured.

Funding under CAP can be used to support a variety of projects to improve access for all levels of care for the uninsured and under-insured. Each community designs a program that best addresses the needs of the uninsured and under insured and the providers in their community. Funding is intended to encourage safety net providers to develop coordinated care systems for the target population.

The majority of the CAP funds will be used to support expenses for planning and developing an integrated health care delivery system. A small portion of the funds may be used for direct patient care if there are gaps to putting together an integrated delivery system.

Applications for the CAP demonstration project were due this past June; 208 were submitted by groups from 46 states and the District of Columbia. Applications were evenly distributed between urban and rural areas, and six were submitted by tribal organizations. About three fourths of applications came from communities with rates of uninsured persons higher than the national average of 14%. Half of applications came from communities with rates of uninsured persons greater than 20%. Close to 90% of applications target all uninsured persons in an area.

Perhaps the best way of explaining how CAP can improve a community's health care networking is to paraphrase from the application submitted from a group in Houston. The lead applicant, Harris County, is the third most populated county in the nation and the most populated county in Texas with about 3.2 million residents. Close to 50% of our residents are Anglo, about 18% are African American, about 27% are Hispanic and about 5% are Asian. The Asian population is the fastest growing, followed by Hispanics and African Americans.

According to Harris County's proposal, "population growth and an economic boom have enhanced the overall wealth and employment opportunities of the community. It has, however, also resulted in greater economic disparities between the privileged and the economically disadvantaged. The numbers of uninsured and under insured are on the rise."

The Texas Health and Human Services Commission estimated that in 1999, 25.5% of the total population in Harris County—834,867—was uninsured. Of this total number, the applicants have targeted three populations: First, they will target those with incomes under 200% of the federal poverty level (428,369 persons). Second, they will target those with incomes over 200% of the federal poverty level (301,000 persons). Third, they win target those who are under insured (328,183 persons).

According to Harris County, the primary focus of this project is to improve the interagency communication and referral infrastructure of major health care systems in the city. This will improve their ability to provide preventive, primary and emergency clinical health services in an integrated and coordinated manner for the uninsured and under insured population. Harris County will place particular emphasis on the development and/or enhancement of the existing local infrastructure and necessary information systems.

In addition to expanding the number and type of providers who participate in collaborative care giving efforts, Harris County would establish a clearinghouse for local resources, care navigation and telephone triage to increase accessibility and reduce emergency room care. The clearinghouse will receive referrals of uninsured patients from health service providers and patient self-referrals. The consortia will give special attention to health disparities in minority groups. It will establish a database for monitoring, tracking, care navigation and evaluation. In Harris County, it is expected that this initial support from grant funds would become self-sustained through contributions from participating providers, especially smaller primary care providers who can rely

on the centralized triage program for after-hours response.

Harris County will also develop a plan to allow private and public safety-net providers to share eligibility information, medical and appointment records, and other information. The program will beef up efforts to make sure families and children enroll in programs for which they might be eligible, including Medicaid and the Childrens' Health Insurance Program (CHIP). In addition, Harris County would facilitate simplified enrollment procedures for childrens health programs.

Among those participating in the Harris County group are the Asian American Health Coalition, the Baylor College of Medicine's Department of Family and Community Medicine, Communities Conquering Cancer, Community Education and Preventive Health, the Dental Health Task Force of the Greater Houston Area, the Gulf Coast CHIP Coalition, the Harris County Budget Office, the Harris County Hospital District, the Harris County Public Health and Environmental Services, the HIV Services Section, the Homeless Services Coordinating Council and the Houston Health and Human Services Department.

Also part of this consortia are the Mental Health/Mental Retardation Authority of Harris County, the Ryan White Planning Council, The Assistance Fund, The Rose, and the University of Texas's Health Science Center's Department of Internal Medicine.

What does this group hope to accomplish? It has four goals.

1. Establish a county-wide communication and referral system accessible to Community Health Partners, Affiliates, Clients and Funding Resources.

2. Document referrals from the Community Health Access Clearinghouse to Community Health Partners, Affiliates and Funding Resources.

3. Decrease the rate of non-emergency use of emergency rooms.

4. Increase the numbers of low-income persons with insurance coverage.

This group's plan—and it's a great one—is just one of 208 that were submitted to HRSA this June. Unfortunately, since funds exist only for about 20 projects, Houston and other cities and rural areas may get turned away unless Congress acts to pass the Community Access to Health Care Act of 2000.

Putting together the CAP application was the first step in building new collaborative efforts for many groups. I have heard of instances where providers serving the same populations in the same towns had never sat down at the same table together. Once they do, and once they begin to exchange information and ideas, great things can happen.

We in Congress have argued for years about the federal government's role in ensuring access to affordable health care. I believe that some type of universal care should be a priority for the long term. For the short term, however, authorizing the CAP program will place much-needed funds in the hands of local consortia who, working together, can help to alleviate this crisis—town by town and patient by patient. I am pleased to note that this legislation has also been included as part of Rep. Dingell's FamilyCare Act of 2000, of which I am a cosoponsor.

In closing, I would like to recognize a person whose dedication to this effort has led to the introduction of this legislation today. Dr. Mary Lou Anderson, from the Health Resources Services Administration, actually came out of her retirement to oversee the CAP demonstration project. Her dedication to this project, and to the health of America's families and children, is commendable.

HONORING THE MINNESOTA RIVER BASIN JOINT POWERS BOARD

HON. DAVID MINGE

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 26, 2000

Mr. MINGE. Mr. Speaker, today I recognize five years of outstanding work by the Minnesota River Basin Joint Powers Board to coordinate the clean up of the thirty-seven county Minnesota River Basin.

Since its inception in 1995, the Minnesota River Basin Joint Powers Board has been able to build progressive and trustworthy relationships among agricultural production, conservation, sporting, and environmental interest groups. They have also been instrumental in building sustainable relationships with local, state, and federal government agencies in order to advance the cause of a restored, fishable, and swimmable Minnesota River.

The Minnesota River Basin Joint Powers Board has also been extremely helpful in promoting the Minnesota River Basin's Conservation Reserve Enhancement Program. Minnesota River CREP hopes to retire and restore 100,000 acres of flood-prone farmland in order to improve water attributes in the Basin and the larger Mississippi River Basin as a whole. Furthermore, their ability to thoughtfully and even-handedly coordinate the needs of thirty-seven counties regarding watershed team tributary strategies has been important to the success of this basin-wide initiative.

I would also like to recognize this group's Executive Director, Steve Hansen, as a tireless and articulate advocate of water quality improvement and the State of Minnesota's continuing environmental commitment to its rivers and natural resources.

In conclusion, I would like to stress the importance of the integrative and comprehensive watershed planning that the Minnesota River Basin Joint Powers Board is engaged in to promulgate and implement successful recovery of this important natural resource—the Minnesota River.

IN REMEMBRANCE OF AMBASSADOR BIRABHONGSE KASEMSRI

HON. DANA ROHRABACHER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 26, 2000

Mr. ROHRABACHER. Mr. Speaker, this week, a long-time friend of the United States, Ambassador Birabhongse Kasemsri, known as Bira to his friends, passed away in his hometown of Bangkok, Thailand. I last saw Ambassador Kasemsri, 65, in 1999 during a visit I was honored to have with Thailand's King Bhumibol, whom Bira served as His Majesty's principal private secretary. In service to his King and country, Bira, was granted three decorations, including Knight Grand Cordon of the Most Noble Order of the Crown of Thailand [Highest Class].

Too often, American policymakers underestimate the importance of our strategic alliance with Thailand, which extends to our Civil War when the King offered President Lincoln a herd of fighting elephants from the Royal Thai military. Ambassador Kasemsri reinforced the strategic relationship during the height of the post-Vietnam Cold War period, during his exemplary service as Thailand's ambassador to the United States. In addition, during the early 1980's while he served as Thailand's ambassador to the United Nations, Bira was a hero of the Reagan doctrine in Southeast Asia by protecting Thailand from communist aggression. During that time, Bira was instrumental in arranging for noted military historian and journalist Al Santoli—who currently serves as my foreign policy advisor—to visit areas of Thailand that were under attack by the Soviet-backed Vietnamese communist army and their surrogates from Cambodia and Laos. Thanks to the sponsorship of Ambassador Kasemsri, the articles that Al wrote for the New Republic and Parade magazines on the threat to Thailand directly contributed to the cessation of chemical warfare in Indochina and the withdrawal of the Vietnamese occupation forces in Cambodia.

On behalf of my wife Rhonda and I, and my colleagues who have had the pleasure of working with Ambassador Kasemsri over many years, I extend deepest sympathy to his wife, Rampiarpha and their three children. I believe that the seeds of solidarity that Bira sowed during his many years of representing The Royal Government of Thailand in America will lead to further development of the friendship between the governments and people of Thailand and the United States.

TRIBUTE TO THE LATE MACEDONIO A. PADILLA

HON. GRACE F. NAPOLITANO

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 26, 2000

Mrs. NAPOLITANO. Mr. Speaker, it is with particular sadness that I offer this memorial tribute to Mr. Macedonio A. Padilla of Pico Rivera, California, a politically active citizen of the 34th Congressional District. Mac Padilla served his community with an inspired passion for education, insisting on the importance of broadening the horizons of young minds.

Born in Los Angeles, California, on September 12, 1929, Mr. Padilla grew up with his family in the greater Los Angeles community. Having not completed his high school education, he enlisted in the United States Army and served his country in World War II.

He had two daughters, Sylvia and Margaret, with his first wife, Antolina Barba, whom he married in 1950 and divorced some years later. As a single man, he was employed at